STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

ONLINE CLINICAL NURSE SPECIALIST APPLICANT IDENTIFICATION FORM

You must complete and submit this form via your online BreEZe account, or by mailing to:

Board of Registered Nursing, ATTN: Advanced Practice Unit, P.O. Box 944210, Sacramento, CA 94244-2100.

Print Full Name: _____ _____ _____
(Last) *(First)* *(Middle)*

U.S. Social Security Number or Individual Tax Identification Number: _____ **E-Mail:** _____

Address: _____ **Date of Birth:** _____

Name of Clinical Nurse Program: _____

City, State and Country of Clinical Nurse Specialist Program: _____

HAVE YOU COMPLETED AND/OR ENCLOSED THE FOLLOWING ITEMS (check all that apply):

Have you attached a recent 2" x 2" **passport type photograph**? ☐ **YES** ☐ **NO**

If applicable, if you are relocating to California as a result of your spouse's/partner's active duty military service, is the supplemental information enclosed? ☐ **YES** ☐ **NO**

If applicable, is supplemental information regarding reporting prior convictions or discipline against licenses enclosed? ☐ **YES** ☐ **NO**

I certify under penalty of perjury under the laws of the State of California, that all information provided in connection with this online application for licensure is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.

Signature of Applicant: _____

Date: _____

Tape Your 2" x 2"

Passport Type

Photograph Here